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MEDICAID MEMO

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Clarification of Cost Sharing for Dually Eligible Medicaid/Medicare Recipients

The purpose of this Medicaid memorandum is to provide clarification of certain Medicaid policies that impact Medicare Part B claims for dually eligible (Medicare/Medicaid) recipients. There are two separate cost sharing issues regarding dual eligibles that will be discussed below: (1) appropriate process to bill for copayments when enrolled in Medicare Advantage plans and (2) allowable compensation for mental health services.

State Medicaid programs have historically been required to pay Medicare cost-sharing amounts for Medicare beneficiaries who also meet certain Medicaid requirements. Under the standard Medicare Part A and Part B fee-for- service programs, this cost sharing consists of premiums, coinsurance, and deductibles. However, with the passage of the Medicare Modernization and Prescription Drug Improvement Act of 2003, new private sector health insurance options were introduced to beneficiaries. The Medicare Advantage (MA) program offers alternatives to the standard Medicare Part A and Part B programs on an elective basis and many of these MA plans use the "copayment" in lieu of a deductible and/or coinsurance.

1. Process to Bill for Copayments When Enrolled in a Medicare Advantage Plan

Based on the original description of cost sharing under Medicare, the Virginia Medicaid claims payment system has excluded the copayment from the permissible cost sharing of deductibles and coinsurance. In order for Virginia Medicaid to appropriately process allowable cost sharing amounts, Medicaid providers should enter the copayment amount in the coinsurance locator field (field 21), the coinsurance amount in the coinsurance locator field (field 21) and the deductible in the deductible locator field (field 20) on the claim form (see example on enclosed form) subsequent to the Medicare Advantage plan processing the claim. Should a Medicare Advantage Plan include a copayment and coinsurance amount on their explanation of benefits, providers will need to combine the dollar amounts in the coinsurance locator field. The deductible is always to be billed in the appropriate locator field (20) and should not be combined with the copayment or coinsurance amount(s). Please be advised that Virginia Medicaid will provide reimbursement up to the Medicaid allowable amount for each service. In addition, Medicaid providers cannot balance bill dual eligibles for charges in excess of the allowable amounts.

2. Allowable Compensation for Mental Health Services

A recurrent issue that continues to confound mental health providers is the reduced Medicare payment for "treatment of mental, psychoneurotic and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred" (Section 1833(c) of the Social Security Act). This provision established a coinsurance rate of payment (62.5%) that is inconsistent with other outpatient services (80%). Furthermore, Medicaid is required to pay differently for dual eligible recipients based on their level of income. Those dual eligibles who have full

Medicaid benefits and help with Medicare cost sharing (QMB-plus) are not responsible for any portion of the allowable charge, except for the Medicaid copay required, and they may not be balance billed. QMB-only beneficiaries, however, are responsible for a portion of the billable amount.

Under the above provisions, Medicare may only consider 62.5% of the Medicare allowable cost for payment which is further reduced by the required beneficiary cost sharing (i.e., deductible if yet unmet and 20% coinsurance amount). Thus, the actual payment to the provider is equal to 50% of the allowable amount and the other 50% is the patient responsibility ("Explanation of Benefits" shows amount as 12.5% in coinsurance obligation and 37.5% as patient responsibility). Medicaid is limited to paying only the 20% coinsurance amount (equal to the 12.5% of the reduced allowable amount) for the QMB-only beneficiaries but may pay up to the full Medicaid allowable amount for the QMB-plus enrollees. While the QMB-plus enrollees are only responsible for minimal Medicaid copayments, the QMB-only is responsible for the 37.5% remainder of the Medicare allowable amount and the provider may balance bill.

Example: Medicare allows $100 for outpatient psychiatric services and Medicaid pays $80 for this same service.

QMB-plus recipient: Medicare pays $50 to the provider with $12.50 being patient copayment and

$37.50 being patient responsibility. Medicaid would pay $30 (less any Medicaid copay) and the remainder could not be billed to the patient.

QMB-only recipient: Medicare pays $50 to the provider with $12.50 being patient copayment and

$37.50 being patient responsibility. Medicaid would pay $12.50 and the remainder ($37.50) would be patient responsibility for which the provider could balance bill the patient.

The above referenced inconsistency in level of payment for outpatient mental health services versus other health care services has been addressed in subsequent legislation to "normalize" the mental health payments by increasing Medicare's contribution over time, as per the following schedule.

A. for expenses incurred in years prior to 2010, only 62 1⁄2 percent of such expenses;
B. for expenses incurred in 2010 or 2011, only 68 3⁄4 percent of such expenses;
C. for expenses incurred in 2012, only 75 percent of such expenses;
D. for expenses incurred in 2013, only 81 1⁄4 percent of such expenses; and
E. for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices are no longer printed and mailed free of charge. Duplicate remittance advices are now processed and sent via secure email. A processing fee for generating duplicate paper remittance advices has been applied to paper requests, effective July 1, 2009.

ALTERNATE METHODS TO LOOK UP INFORMATION

As of August 1, 2009, DMAS authorized users now have the additional capability to look up

service limits by entering a procedure code with or without a modifier. Any procedure code entered must be part of a current service limit edit to obtain any results. The service limit information returned pertains to all procedure codes used in that edit and will not be limited to the one procedure code that is entered. This is designed to enhance the current ability to request service limits by Service Type, e.g., substance abuse, home health, etc. Please refer to the appropriate Provider Manual for the specific service limit policies.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or

FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com.

The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884- 9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.